With the invention of the automobile came the necessity for a speed limit in Fairfield. On December 4, 1899, an ordinance was passed designating a speed limit of 8 miles per hour. A couple of years later, the speed limit was increased to 10 miles per hour (five miles while turning corners) for any horse, mule or vehicle. The ordinance also indicated that any wheeled vehicle must have a bell or gong of sufficient power to give warning of an approach. In 1919, it came to the attention of the Township committees that the Passaic River had become a popular recreational area and the committee found it necessary to make it unlawful to bathe in the waters of Caldwell Township without being clothed. Other problems involving the river had become more serious. The lowlands have always been subjected to flooding. In fact, the Township's flood control program dates back to 1844.

The 1930's saw Fairfield begin to evolve from a farm community to a more suburban community. As the population continued to increase over the 1,000 person mark, an organized police department was established in 1937. The year 1940 saw industrial development move into Fairfield with the construction of the Curtis Wright airplane factory. In the 1960's a campaign for a municipal name change was underfoot. As the community's population continued to boom it was apparent that the Township was in need of its own postal facility. However, the Township of Caldwell found itself unable to obtain a facility under that name because of the confusion with Caldwell Borough, the post office through which the community was served. As a consequence, Mayor Stepehen Szabo suggested that the municipality again become known as Fairfield. The idea was quickly endorsed by other local officials and from most of the community.

Mr. Speaker, my fellow colleagues, please join me in congratulating the Township of Fairfield and its citizens as they celebrate this milestone.

SPORTSMEN'S MEMORIAL ACT OF 1998

HON. JOHN J. DUNCAN, JR.

OF TENNESSEE

IN THE HOUSE OF REPRESENTATIVES

Thursday, June 18, 1998

Mr. DUNCAN. Mr. Speaker, today, I introduced the Sportsmen's Memorial Act of 1998. This legislation will honor this Nation's sportsmen by initiating a process through which a memorial will be established in, or around, the District of Columbia.

I think everyone will agree that the conservation of the Nation's fish and wildlife resources is of critical importance to all of our citizens.

Many government agencies have been created to manage our natural resources. In addition, many national, state and local associations have been established to support conservation efforts.

However, standing at the forefront of these collective efforts are sportsmen, whose financial support to the Nation's fish and wildlife conservation efforts number in the tens of billions of dollars.

Sportsmen have been the financial and philosophical backbone of successful fish and wildlife management throughout the 20th century.

The support of these individuals has allowed fish and wildlife managers to protect and restore millions of acres of habitat, engage in quality research on a multitude of fish and wildlife species, and actively manage our natural resources on a day-to-day basis.

In addition, sportsmen, through their purchase of state hunting and fishing licenses, stamps, and tags, have contributed billions of dollars directly to wildlife agencies.

This support has allowed fish and wildlife managers to achieve some of the greatest success stories.

For all of these reasons, I believe it is appropriate that we honor these men and women with a memorial in the National Capital Region.

I encourage all of my colleagues to join me in honoring the sportsmen of this Country by cosponsoring the Sportsmen Memorial Act of 1998.

JOINT HEARING—SENATE LABOR AND HUMAN RESOURCES AND HOUSE COMMERCE COMMITTEE; ORGAN DONATION ALLOCATION

HON. FORTNEY PETE STARK

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Thursday, June 18, 1998

Mr. STARK. Mr. Speaker, I would like to commend Chairmen JEFFORDS and BLILEY for conducting hearings on the problem of organ allocation. As they well known, organs have not been allocated in a fair way to benefit patients in the past and we are in a position now to take a stand for patients and for fairness.

This is a simple issue of fairness and quality. If you are a patient in need of a transplant and you live in Tennessee, the average time you spend on the waiting list is about 21 days. If you live in my part of the country, the San Francisco Bay Area, the average waiting time for that same patient is over 300 days.

In every part of the country, the Cleveland Plain Dealer reports that minority candidates wait longer than their white counterparts for available organs.

Is this fair? When my good friend Congressman MOAKLEY was diagnosed with hepatitis B and was in need for a liver transplant, his doctors told him to leave Boston and move to Virginia to increase his chances of obtaining a liver.

Fairness is half of this fight. Quality is the other. There is a lot of money to be made in organ transplants. Too many centers have been opened to increase the prestige and the profits of a local hospital—and not because they do a good job. In fact, in general the lower volume small transplant centers have poorer outcomes than the high volume transplant centers. The fact is, having a transplant center has become the equivalent of health pork. Many of these centers are like the excess projects in the recently-passed highway bill: centers without a justification. But unlike highway pork, these centers often end up killing patients because they do not do as good a job as the high volume centers. I really think it is immoral for centers who have a lower success rate than the high volume centers to be fighting the Department's regulation. Their actions are a disgrace to the Hippocractic Oath.

The proliferation of poor quality transplant centers not only wastes lives, it wastes money. The United States has 289 hospitals doing transplants—and that is an enormous commitment of capital. I have read that a hospital has to invest about $10 million to be able to do heart transplants.

These proliferating costs are part of what drives health inflation in the United Sates and part of what places such huge budget pressures on Medicare. Concentrating transplants in fewer, high-quality, life-saving centers would allow us to save hundreds of millions of dollars in the years to come. The Department's regulation gives us the potential to focus on Centers of Excellence where we not only save lives, but can obtain economies of scale necessary to preserve the Medicare program.

If my colleagues are serious about putting patients first, what is so onerous about a system that proposes to base transplant decisions on common medical criteria on a medical need list—not geography, not income, not even levels of insurance coverage—just pure professional medical opinion and medical need.

This hearing is about putting patients first—not putting transplant bureaucracies first. I can think of no better way to put patients first than to make the system fair for all. I urge the Committees to support the Department's regulations.

A BILL TO AMEND THE INDIAN HEALTH CARE IMPROVEMENT ACT

HON. DON YOUNG

OF ALASKA

IN THE HOUSE OF REPRESENTATIVES

Thursday, June 18, 1998

Mr. YOUNG of Alaska. Mr. Speaker, I am pleased to introduce legislation with my distinguished colleague, Mr. DALE KILDEE of Michigan, to amend the Indian Health Care Improvement Act (IHCIA). In 1988, pursuant to Section 405 of the IHCIA, the Indian Health Service (IHS) was directed to select up to four tribally-operated IHS hospitals to participate in a demonstration program to test methods for the direct billing for and receipt of payment for health services provided to Medicare and Medicaid eligible patients. This was established to determine whether collections would be increased through direct involvement of tribal health care providers versus the current practice which required billings and collections be routed through the IHS.

In 1996, Congress extended this demonstration program until 1998. This extension allowed Congress additional time with which to consider whether to permanently authorize the collection program. The law also required the IHS to submit a report to Congress on the demonstration program on September 30, 1996, the same day the program was originally to expire. The report was to evaluate whether the objectives were fulfilled and whether direct billing should be allowed for other tribal providers who operate an IHS facility. This report is still undergoing Departmental review, however, it is our understanding that the Secretary of Health and Human Services and the Indian Health Service are very pleased with the success of the demonstration program.